September 15, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1692-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. This physician is board certified by the American Board of Osteopathic Internal Medicine. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 44 year-old male who sustained a work related injury on ___. The patient reported that while at work he was involved in a motor vehicle accident injuring his left arm. The patient underwent left elbow surgery on 12/3/01. Treatment for this patient has included stellate ganglion blocks, physical therapy, hot packs and pain medications. The patient has been prescribed an RS4i sequential stimulator for daily home use for treatment of continued pain in the left upper extremity.

Requested Services

Purchase of an RS4i sequential stimulator 4 channel combination interferential & muscle stimulator unit.

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer noted that this case concerns a 44 year-old male who sustained a work relate injury to his left arm on ___. The ___ physician reviewer also noted that the patient underwent left elbow surgery on 12/3/01. The ___ physician reviewer further noted that the patient has been treated with stellate ganglion blocks, physical therapy, hot packs and pain medications. The ___ physician reviewer indicated that the patient has been further treated with an RS4i sequential stimulator. The ___ physician reviewer also indicated that functional electrical stimulators/Neuromuscualr electrical stimulators may be considered medically necessary for disuse atrophy when the nerve supply to the muscle is intact and the patient has either previous casting/splinting of a limb, contractures due to burn scarring or recent hip replacement surgery (up until the time physical therapy begins) and/or previous major knee surgery when there is failure to respond to physical therapy. The ___ physician reviewer explained that the documentation provided did not include any physician progress notes that support the medical necessity of this treatment. The ___ physician reviewer indicated that there were two prescriptions included in the documentation provided. The ___ physician reviewer explained that the first prescription does not list a diagnosis of atrophy. However, the ___ physician reviewer also explained the second prescription does. The ___ physician reviewer further noted that the treatment, exam and results of the treatment are unknown due to lack of documentation. Therefore, the ___ physician consultant concluded that the requested purchase of an RS4i sequential stimulator 4 channel combination interferential & muscle stimulator unit is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 15th day of September 2003.